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ABSTRACT

The Draper Fund was established within the Population Crisis Committee (PCC) in 1975. Contributions to the fund are used by the PCC to encourage and expand those activities which promise the greatest impact in slowing world population growth. Seven papers written around that theme are included in this report: "The Crucial Role of the Private Sector" (Mary Barberis and John M. Paxman); "Promoting Family Planning through Women's Development" (Kaval Gulhati); "Tapping Private Industry" (Bradman Weerakoon); "Enlisting Private Practitioners" (I-cheng Chi and May Huang); "Motivating Communities through Economic Incentives" (Mechai Viravaidya and Donald Weeden); "Social Marketing of Contraceptives" (William P. Schellstede and Bonnie B. Derr) and "Introducing New Contraceptives" (Sheldon J. Segal and Elsimar Coutinho). (BZ)

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TOWARDS SMALLER FAMILIES:

The Crucial Role of the Private Sector

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DRAPER FUND REPORT
Number 15

December 1986

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William H. Draper, Jr.
1894-1974

The Draper Fund of the Population Crisis Committee

The Draper Fund was established within the Population Crisis Committee in 1975 to honor PCC's principal founder, the late General William H. Draper, Jr. Contributions to the Fund are used by PCC to encourage and expand those critical activities which promise the greatest impact in slowing world population growth. The funds are directed to responsible organizations with overseas staff for key action projects which cannot be initiated without private sector support. Among such agencies is the International Planned Parenthood Federation, with member affiliates in 123 countries. In 1975 PCC established the Special Projects Fund to serve selected large donors who wish 100 percent of their contribution directed to specifically designated projects.

Although in the long run major new commitments from governments will be needed to solve national population problems, the role of the private sector remains indispensable. Nongovernmental organizations, using worldwide networks of volunteers, represent a vital and constructive force in influencing how soon and how soundly governments move. As General Draper often pointed out, contributions to such organizations can "do more good, dollar for dollar, than any similar amount employed in any other way."

The Draper Fund Report

1120 Nineteenth Street, N.W., Washington, D.C. 20036

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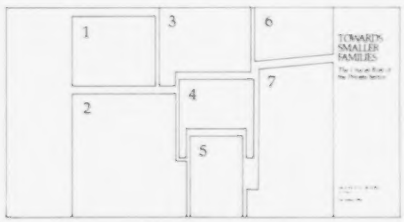

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Bangladesh: Private organizations introduce family planning to couples around the world. This store sells inexpensive contraceptives provided through private funds from abroad.

PSI

The Crucial Role of the Private Sector

Mary Barberis and
John M. Paxman

Mary Barberis is Senior Research Associate at the Population Crisis Committee. John Paxman is Senior Policy Advisor at The Pathfinder Fund, an international family planning agency founded in 1957 by population activist Dr. Clarence Gamble.

For the last half century private initiative has been the innovative spirit driving family planning efforts in countries around the world. When Margaret Sanger started the privately funded Birth Control League in 1922, she launched one of the most important movements of the 20th Century. Private efforts such as hers pioneered women's reproductive rights and foresaw the emerging concern over the problem of rapid population growth, with its crushing impact on people's health and well-being. Private individuals and organizations recognized the need for smaller families and often stepped in to offer family planning services before governments were ready to act. The private sector has been an engine for change and progress in family planning. In recent years it has expanded its crucial role in the development of family planning programs.

Despite the increase in government family planning programs, private support for family planning continues to grow. Private sector involvement in family planning now includes industries that provide family planning services, labor unions that promote them, commercial establishments such as retail outlets or pharmacies that distribute contraceptives, community groups such as women's organizations, credit unions or perhaps village councils that help build demand for family planning, private medical practitioners who include contraception as part of health care, for profit or nonprofit organizations that provide technical and financial assistance to developing country programs, pharmaceutical firms that develop and sell contracep-

tives, and foundations that underwrite contraceptive research and in-country programs.

Today, private and public family planning programs complement each other, often in close partnership. The mix of private versus public support differs from country to country. Governments often can command greater financial resources and operate on a much larger scale, while private organizations tend to be more innovative. Often, the private sector has involved the public sector in creating joint mechanisms for the delivery of family planning services, taking the lead in pioneering new approaches while working hand-in-hand with government. In so doing, the private sector has earned increasing recognition and support from public funding sources.

The private sector has the advantage that it can pioneer innovative programs the public sector is unwilling or unable to pursue, and it can bring foreign financial and technical assistance to developing countries that governments may be unwilling for sensitive political reasons to accept from other governments. Private organizations and individuals can reach out to people in appropriate ways and involve them in solving their own problems through a grassroots approach. The private sector is often better able than the government to identify the values and fulfill the needs and desires of people in particular community settings. Another of its strengths is its ability to achieve financially self-sustaining family planning efforts which are linked to other development efforts and deeply rooted with the people who are being served.

Private Sector Takes the Initiative

In a number of countries the private sector has been instrumental in developing a national family planning program. The pattern in the developing countries is similar to the earlier experiences in the United States, Britain, Italy, and, more recently, Spain, where private sector groups initiated the process of change in government policy.

Brazil is a leading example of a country where the private sector has played the dominant role. Only in 1986 has the national government of Brazil announced a family planning program. Prior to 1986, private voluntary organizations, the medical profession, and pharmacists played a key role in providing the public with services and persuading local governments to develop family planning programs with the result that Brazil now has one of the highest contraceptive prevalence rates in the developing world and its annual population growth rate has dropped to 2.3 percent.

In Peru, the private family planning association was vitally involved in developing the necessary political support and facilitating the drafting of Peru's Population Law of 1985. It did this through a series of actions that focussed public debate on the issue and provided government policymakers with population information. Even the Mexican government's dramatic turnabout in support of family planning in late 1974 was precipitated by private sector research and exposition that demonstrated to President Echeverria the drastic socioeconomic implications of Mexico's rapid population growth rates.

The 1983 updating of Turkey's laws and policies on family planning was a joint effort in which public and private energies were marshalled in the cause of reform. The advocacy of university groups and the country's most powerful labor confederation figured prominently in the process.

In some cases, it was in large part the effort of private individuals that helped turn government policy around. For example, individuals such as Lady Rama Rao, along with other family planning visionaries, had a significant part to play in influencing India's pioneering role in the adoption of a national population policy as early as the 1950s.

In countries where laws and attitudes encourage independent initiatives, the private sector has often contributed to the widespread use of contraception, working alongside government programs. When Thailand gave the green light to the distribution of contraceptives by nonphysicians, the private Population and Community Development Association seized the opportunity to integrate family planning with many avenues of economic life and distribute contraceptives in innovative ways. In Sri Lanka, private community-based distribution of contraceptives assumed a major pioneering role in the expansion of contraceptive delivery. In South Korea, the private network of Mothers' Clubs has been a significant contributor to the country's widespread prevalence of family planning.

Industrial firms in Japan, India and several other countries have helped promote family planning by setting up family planning services for their employees and in some cases providing incentives for their use. Providing family planning services at the workplace has

Law and Government Policy: Obstacle or Aid to Family Planning Programs?

All private sector initiatives are affected by the political and legal environment. Laws and government policies at the very least cast different lights and shadows on family planning initiatives. They may serve only a symbolic purpose, offer a fundamentally supportive framework, provide detailed solutions, or contribute, by virtue of silence, nothing at all to efforts by the private sector. In some circumstances law and policy inhibit family planning initiatives outright; in others they merely create confusion and ambiguity.

In most countries, those in the private sector carefully seek to obey the law, but this attitude is not without its disadvantages. When new ideas for family planning are mentioned, their response is often, "We can't do that, it's illegal." This is as much a reflection of what they may *think* the law says (or what they think is practically or politically feasible) as it is a statement of what the law actually permits or prohibits. Another common statement made by family planning innovators the world over is, "Everything we do is illegal." In many countries outmoded laws and policies are simply ignored as programs designed to solve pressing population problems are established. History is replete with examples where the private sector has identified the need for legal and policy change, framed the issues, provoked the public policy debate and prompted change. In these settings legal restraints invite reforms.

While law and policy can inhibit family planning initiatives, they can also play a positive role in eliminating the barriers to family planning. Many of the positive inroads that have been made bear the mark of the private sector. In the last decade alone:

- Mexico, Spain, Italy, Cameroon, and the Ivory Coast have legalized the sale and distribution of contraceptives.
- Thirteen countries (including Bangladesh, Pakistan, Colombia, Brazil, and Zimbabwe) have widened the categories of workers who are allowed to supply contraceptives.
- Spain, Senegal, Brazil, Canada, Italy, Jamaica, Cameroon, and the Ivory Coast have allowed increased public information and advertising of contraceptives.
- Thailand, Hong Kong, the United States, Britain, Denmark, China, Mexico, Costa Rica, Sweden, and France now provide family planning services or education for their young people.
- Egypt, Bangladesh, Tunisia, Thailand, and South Korea have eased import requirements on contraceptives.
- Seventy-five countries including Ecuador, Spain, Turkey, Colombia, Tunisia, Mexico, Bangladesh, Nigeria, and Kenya have established a legal basis for voluntary sterilization.
- Forty countries including India, Hong Kong, Zambia, Czechoslovakia, South Africa, Tunisia, Peru, Morocco, and El Salvador have liberalized abortion.

paid off in improved employee morale, less absenteeism, and lower labor turnover. Many labor unions have espoused family planning as a benefit vital to the welfare of their members. As for the workers themselves, experience has shown that when men and women see that family planning is used by their peers and are provided with conveniently accessible services, they readily become contraceptive users.

In and out of the workplace, people regard family planning as an important component in their quest for a better future for themselves and their children. Local community groups and grassroots organizations that provide self-help development initiatives stimulate the desire for smaller families, even in a few cases by making explicit links between fertility control and economic progress. Private nonprofit groups from industrialized countries have had a key role in providing the training, technical assistance, and funding essential to enable these organizations to operate. The private sector has been especially important in pioneering grassroots pro-

grams that improve the status of women by providing them with education, health care, training, and economic opportunities. As women gain knowledge, independence, and self-confidence, they tend to want smaller families and demand family planning services.

Commercial markets and private health care personnel of all types have played a vital role in the distribution of contraceptive services. Of the $2.6 billion spent in 1980 on family planning in the developing world, one fifth was spent by individuals. An innovative approach that now has over a decade of experience—contraceptive social marketing—uses established retail outlets to provide contraceptives at subsidized prices. The private sector approach, both for selling contraceptives and providing services such as IUD insertion or sterilization, has proven very popular among the public, who often perceive that they get better quality and more personalized service than with government programs. Indeed, governments are capitalizing on these perceptions and on the cost-efficiency aspects of using private practitioners to provide services for their national programs.

The pharmaceutical industry and foundations supported by both private and public funds have been instrumental in bringing to life new contraceptive technology. Collaborative efforts between the private and public sectors have resulted in such significant contraceptive advances as the Copper-T intrauterine device, the NORPLANT® system of contraceptive implants, and a potential once-a-month pill to assure menstruation.

Constraining Laws

In many countries private sector initiatives face government imposed constraints, such as laws barring the advertisement of contraceptives, regulations limiting public access to information about family planning, and legal barriers to the use of responsible nonphysicians to deliver family planning services. Such constraints inhibit the private sector from responding to the expressed demand for family planning services. Private organizations and individuals often use their influence to persuade governments to reduce or eliminate these constraints.

Over the years, the private sector has striven to do two things: to identify the ways law and policy restrain the development of family planning programs and then to explore various imaginative approaches which can be taken to eliminate, overcome or avoid these restraints. The desire has been to see that law and policy are utilized to make freedom of choice in family planning matters possible. The challenge, as always, has been to close the gap between legal norms and social facts. It has been the private sector's task to bring law and policy closer to the social facts.

Even where the political and legal climate for family planning is positive, there is much to be done. Where government programs are weak or nonexistent the role of the private sector is to carry the burden of organizing and maintaining mainline programs as well as to act as an agent for the development of new service delivery systems. In many countries, the intrepid, creative work in family planning service delivery is often undertaken outside of the government sphere.

Pioneering by the private sector continues to be crucial for the expansion of family planning. Government policymakers will not change their minds in the absence of proof that a new concept is workable. New ideas must first be tested, successful experience demonstrated. Any departure from long-standing, somewhat comfortable patterns is at best difficult to achieve. Private pilot projects are useful for many reasons, not the least of which is that in the early stages they can serve as "lightning rods," assuming risks that a government is not willing to take.

The private sector has made headway simply by getting on with the task and avoiding the inertia-creating pitfalls of the larger policy process. It can step in where government bureaucracies are ineffective, particularly in reaching remote rural populations. It can strengthen the links between family planning and other development efforts by working with environmental, health, hunger, and other likeminded groups. In the future, it is likely that it will be the private sector that will come forth with breakthroughs to bring contraceptive services where they have been previously unavailable to people who need and want them.

India: Private organizations such as the Centre for Development and Population Activities introduce family planning through projects that are run by women for women.

CEDPA

Promoting Family Planning Through Women's Development

Kaval Gulhati

Kaval Gulhati is President of the Centre for Development and Population Activities, a leading private sector support group for women's development in the Third World.

"Do Kenyan women, especially those from rural areas, really want family planning?" This question has followed Jennifer Mukolwe, program manager of maternal/child health and family planning services for the Maendeleo Ya Wanawake organization in Kenya throughout her career. From Ms. Mukolwe's observations the answer is not only that Kenyans want family planning, but they are building their own grassroots organizations to provide services. "It's not the government, it's not the donors...it's the women themselves who demand family planning, and they are determined," she says.

Founded in 1952 with the objective of uplifting the standard of living for members and their families, Maendeleo Ya Wanawake, Swahili for "progress for women," today constitutes a rural network throughout Kenya. About 7,500 Maendeleo self-help groups exist with involvement in farming, handicrafts, adult literacy, water and energy conservation, skills training, nutrition and health, and other projects and activities the community needs.

As the largest women's organization in Kenya, with over 300,000 members, Maendeleo Ya Wanawake has been in a unique position to distribute family planning services.

In 1983, with funding from the Pathfinder Fund (a nonprofit U.S. foundation that encourages innovative solutions to population problems), Maendeleo launched pilot projects in Kenya's three most populous regions to train 73 volunteers as distributors of contraceptives.

The Government of Kenya cooperated by supplying commodities free. As the distributors have gained the respect of people in their communities, both men and women seek their assistance, many from outside the distribution areas. Every client is individually counseled and referred to a clinic if more than routine family planning services are needed. The program has been so successful that there is a demand to expand it to other regions, with over 340 women waiting to be trained as volunteer distributors.

Setting the Stage for Family Planning

The Maendeleo experience is echoed around the developing world as women realize they can change their lives by earning a small income from such activities as making rugs or grinding and packaging spices. Attitudes change as women in the village begin to have their own earnings. Husbands become more concerned over their wives' health, and women ask about getting better health care for themselves and their children. Couples want to know how to plan and space the number of children they will have.

The project could be in India or Kenya, Egypt or Peru—anywhere in the Third World—where helping women to advance economically increases their desire for family planning. Through training and other assistance programs, the private sector has played a key role in helping women to gain in status—socially, economically, and politically.

Private initiatives in developing countries have been particularly successful in raising women's living standards by enabling them to earn more income and reduce family size. These approaches incorporate a women-to-women strategy: women training other women, not only in how to earn an income from producing and marketing products, but also in the critical skills needed to establish and manage organizations of their own.

Money, Management, and Family Planning

In 1977 Jaya Arunchalam, a social worker in Madras, India, founded the Working Women's Forum with the aim of helping poor urban women increase their capacity to earn money, however small their businesses, by gaining access to credit. It began with 30 women traders who organized as a group to receive low interest loans of 300 rupees ($33) each from the local

India: Poor women line up at a bank set up for them by the Working Women's Forum in Madras. Access to credit increases women's ability to control their lives, including their fertility.

CEDPA

Kenya: Private funders provide money for tailoring and sewing classes for adolescent girls. The development of skills like these help avoid teenage pregnancies.

CEDPA

Kenya: In Kamuthanga, women bake bread to raise money for a family planning clinic.

CEDPA

state Bank of India. They elected a leader who every day collected money from the members to repay the bank. Within a month, this pioneer group achieved a repayment rate of 95 percent and gained so much creditor confidence that the project grew dramatically.

Today, the Forum benefits 36,000 poor rural and urban women working in a vast variety of small businesses and trades such as vegetable vending, managing snack food shops, trading cut cloth, flower and fruit selling, and lace making. These women often provide the only steady source of income for their families. Whether working at home, or at a mobile or fixed site, the women organize into neighborhood and trade groups, giving them access to credit, which they use to expand or start new businesses. An elected group leader encourages each member to repay her loan on time and peer pressure assures it. The Forum has enabled poor women to be granted loans from banks which simply ignored them in the past. It has even opened its own bank, the Women's Cooperative Credit and Social Service Society, to streamline the loan process.

As the Women's Forum members' economic status improves, they ask for help in gaining access to social and health services. The Forum has responded by setting up day care centers and training centers to encourage literacy and help members upgrade their skills in garment making and other areas. Evening classes for children are also offered.

In 1980 Ms. Arunchalam attended one of the Women in Management training programs conducted in Washington, D.C., by the Centre for Development and Population Activities (CEDPA). As a result, the Forum launched its own staff management training program in health and family planning. To improve health conditions at the community level, the Women's Forum now trains local members as field workers to provide health, nutrition, and family planning information and services to families in their neighborhoods.

By Women, For Women

Important to a project's success is that it not only benefits women, but that women have organized it. It is in this area—training the project managers—that private voluntary organizations like the Centre for Development and Population Activities have a vital part to play.

In 1978 CEDPA launched a series of innovative,

five-week workshops for Third World women entitled "Women in Management: Planning and Management of Service Delivery Programs in Family Planning, Health, and Development." The training is aimed at mid-career, mid-level managers from Third World countries who want to sharpen their skills in supervising and training staff, in writing project proposals, and in planning, monitoring, and evaluating effective women-to-women programs. The response has been overwhelming. Since 1978, CEDPA has held 19 Women in Management workshops for about 35 women each, not only in English, but in French, Spanish, and Arabic. At the request of some of the women trained in Washington, CEDPA has also helped organize two-week training programs in several countries for local women managers.

As a result of these workshops, CEDPA trainees in ten countries have established voluntary organizations through which CEDPA channels funds and technical assistance for projects in health, family planning, nutrition, and income generation. A 1985 cooperative agreement with the Office of Population of the U.S. Agency for International Development will enable the expansion of funds and technical assistance for long-term family planning service delivery projects developed and run by the women themselves.

Management training is critical because it enables women to sustain the organizational framework for self-help programs, and, ultimately, to keep the programs going. Amal Fouad, a senior official with the Federation of Social Services in Alexandria, Egypt, who was trained at CEDPA in 1978, says, "The Women in Mangement training gave me the skills, know-how, and self-confidence to introduce a participatory training approach, which was new for Egypt, and which is invaluable in working with women volunteers at the community level."

Through the local organization established as a result of CEDPA's Women in Management program, management training for Egyptian women has led to the development of integrated projects at the community level. For example, several rooms of the Islamic Community Development Association Center in Aswan have been set aside for sewing courses, a day-care center, and a family planning clinic. Women take courses in sewing children's clothes, women's skirts, and traditional Egyptian robes, which are sold in a shop especially set up next door. In the first three months of the project, family planning information sessions at the center increased contraceptive users by over a hundred.

From Managers to Policymakers

Women who are able to move from managerial into policymaking posts are in the best position to help other women in their countries raise their status politically, socially, and economically. The Honorable Phoebe Asiyo, the only elected woman member of parliament in Kenya, is now in such a position. Before her political career, she had attended a CEDPA Women in Management workshop and returned to Kenya to help organize a project in the South Nyanza District to train traditional birth attendants to dispense family planning services. CEDPA provided "seed money" for the project. In talking about the importance of family planning efforts in Kenya today, Ms. Asiyo uses this project as a model because its women-to-women approach made family planning accessible and acceptable to women in rural areas.

Speaking at a panel of women leaders on reproductive health care at the Nairobi Women's Conference in 1985, Ms. Asiyo emphasized that policymakers must incorporate population education into development programs. She also saw the important role of nongovernmental organizations: "Small but effective projects can go a long way, not only to supplement government action but by working side by side with governments."

Yet, despite the progress of the past decade, the lot of many women in the developing world remains desperate. Although they account for two-thirds of the world's work hours, women officially constitute only one-third of the labor force, receive only 10 percent of its income, and own less than one percent of its property. In Africa and Asia, they produce 60 to 80 percent of the food; in Latin America, 40 percent. In the developing world, most women spend all their childbearing years either pregnant or nursing children. The migration of men to the cities results in women alone heading at least 17 percent of the households in the developing world—30 percent or more in some rural areas.

It has become increasingly apparent that building formal structures such as the Working Women's Forum and Maendeleo Ya Wanawake to shelter self-help projects enables women to sustain their efforts, enhance their leadership, and strengthen their voices in creating policy.

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India: The Tata Iron and Steel Company of Jamshedpur has been a forerunner in offering family planning services to its employees.

GOVERNMENT OF INDIA INFORMATION SERVICES

Tapping Private Industry

Bradman Weerakoon

Bradman Weerakoon is Secretary-General of the International Planned Parenthood Federation, the private voluntary organization of independent family planning associations in 123 countries.

In the 1950s Nippon Steel of Japan, investigating the causes of industrial accidents, found that 70 percent could be traced to worker stress at home. The problems of large families often take workers' minds off their jobs. Large families also are associated with employee absenteeism and high labor turnover. Such findings spurred Nippon Steel to become one of the first companies anywhere to initiate a large employer-based family planning program.

Many other firms throughout Japan and around the world have since come to realize that family planning is good for employee morale *and* company profits. By 1960 some 115 companies in Japan were providing family planning services to their employees under what had become known as the "New Life Movement"—a movement aimed at improving living conditions for workers.

About the same time as Nippon Steel's initiative in providing family planning services for its workers, India's largest industrial house, the Tata Iron and Steel Company, started a family planning service at its Jamshedpur works near Calcutta, integrating the program into the company's maternal and child health services 10 years later. By 1986, Jamshedpur and its surrounding villages had a population of about 500,000, almost half of whom were covered by Tata's social welfare program. Sixty-five percent of company couples now use modern contraceptives, and Jamshedpur's urban birthrate has fallen to about 28 per 1,000, compared with a national average of 33 per 1,000.

Good for Business and Labor

These Japanese and Indian efforts proved that family planning programs not only bring welfare benefits to workers, but commercial advantages to businesses. In an effort to promote stability and productivity, an increasing number of Third World companies are providing housing, medical care, and sometimes schools for the families of their workforces. But the success of such programs depends very much on the size of workers' families.

Because workers' family welfare is closely linked to labor welfare and productivity, the trade union movement has started to become active in promoting family planning activities. Trade unions kindle the hope of improving the quality of life for workers. Unionized workers may, therefore, be particularly receptive to understanding the benefits of family planning. The Indian National Trade Union Congress, for example, organizes population education classes in factories and trains volunteer family planning motivators.

Where women make up a large proportion of the workforce, maternity leave, paid and unpaid, adds to costly interruptions in production schedules and the need to train replacement workers. Factory-based family planning programs have often cut pregnancy rates in half. Most women employees welcome family planning services since the risk of unplanned pregnancies tends to jeopardize job security as well as adding stress to their home situations.

There are many reasons for special involvement by the industrial sector in family welfare programs. It represents a growing portion of most developing country populations, and services can be made easily accessible at industry work sites or neighboring housing colonies. Furthermore, because a large number of workers in industry have a rural background, their links with the informal workforce and rural communities help spread family welfare ideas throughout the population.

A Model Industrial Program

Godrej Enterprises of India, started promoting family planning in 1957. It provides a model of how family planning has been incorporated into a comprehensive employee welfare system in a factory complex on the outskirts of Bombay, where about half the workers live in high-rise apartments in the company township of Pirojsha Nagar.

Indonesia: For over ten years, some Indonesian firms have provided their employees with family planning services along with health care.

PATHFINDER

From the moment of recruitment, employees receive the message that Godrej encourages workers to have small families. Family planning services are an integral part of the company's comprehensive employee benefits package. Godrej Pragati Kendra, a family welfare center staffed by the firm, provides workers' families with classes in literacy, sewing, Hindi, nutrition, shorthand, and typing, as well as a mobile library, and scouting, gym, and yoga clubs. Kreeda Kendra, the social club, provides a further range of activities and entertainment. There are antenatal and well-baby clinics with immunization services, school health checks, and full-time dental care in addition to contraceptive services. A system of cottage industries provides extra earnings for the wives of male workers.

The pride of the welfare system and one of the keys to the successful family planning program are the Godrej schools. Well staffed, with modern airy buildings and small classes, they provide excellent educational opportunities for pre-primary, primary, and secondary students. By raising the standards of education and workers' expectations regarding their children's future, the company underscores the belief that it is in the employee's own interest to limit family size.

To further reinforce the idea of family planning, incentives are offered to families with three or fewer children. The first and least important incentive is a nominal monetary reward. Much more persuasive is the company rule on limiting school admission. The children of workers with large families must attend a neighboring school where the standards are lower and where the parents may have to pay full fees. Another important incentive is housing and the provision of company apartments. The firm is more inclined to give loans to workers with small families, and maternity benefits are only available to employees with three or fewer children spaced at least three years apart.

The successful results of Godrej's policy are apparent not only in the number of employees who have espoused modern family planning, but in the reduction of infant mortality to about 5 per 1,000 births compared to a national rate of at least 80 per 1,000 births. Malnutrition is rare; polio and measles diseases of the past. One plant manager noted that many sons and daughters of workers have earned university degrees. Some have become qualified engineers and have themselves joined the company.

Industry Programs Around the Globe

Many examples demonstrate the growing support for family planning projects in industries throughout the Third World.

India Successful family planning programs on Indian tea estates, where women make up more than half the workforce, were started in 1957 with the help of the Family Planning Association of India. In 1971 the United Planters' Association of Southern India (UPASI) introduced a "no birth bonus scheme" on three tea estates, contributing 5 rupees each month into a worker's account as long as she did not become pregnant. It also introduced a system of creches for the young children of workers. The next year, thanks in part to a government grant, a comprehensive labor welfare scheme was launched on a larger group of estates employing 260,000 workers. This program combined the promotion of personal and environmental hygiene, cultural and sports activities, preventive medicine and health care, child care, and nutrition with family planning. By 1978, the birthrates on these two groups of UPASI estates had fallen to 21 and 25 per 1,000, from 1970 rates of 39 and 42, while over the same period the national rural birthrate fell only two points, from 39 to 37.

Now, more than 200 leading firms in India operate extensive family planning promotional and service programs. Among these are some sugar factories included in the DCM Group, the Bajaj Group, and the Saraswati Sugar Mills. If the rest of India's powerful sugar industry were to join in a nationwide family planning program, it would be a formidable influence among the 25 million growers in the country.

Because of the success of industry programs, the Indian Family Planning Association and its energetic president, Avabai Wadia, are pressing the government to introduce legislation requiring both large private and public sector companies to provide family planning education and services for all workers and their families.

Thailand In Thailand, the Planned Parenthood Association's industrial project operates in collaboration with factory owners, labor unions, and the Thai Department of Labor. It aims to integrate family planning services into workers' welfare schemes, stimulate management interest in family planning, and, in the

Hand-in-Hand for Family Planning

Turkey has a population of 52 million, a per capita income of $1,160, millions of unemployed workers, and an annual population growth rate of 2.8 percent. The goals of the government's population program include cutting fertility from 4.3 to 2.5 children per married woman and increasing contraceptive use rates from 20 percent to over 60 percent by the year 2000. Those ambitious plans cannot be accomplished by the public sector alone.

Established in 1985 as a partnership between the business and labor communities, the Turkish Family Health and Planning Foundation encourages the active involvement of the private sector in family planning activities. The foundation is the brainchild of business leader, Vehbi Koc, who, in proposing the creation of the foundation at a meeting of key business and labor figures, said, "I believe this initiative should come from the private sector, complementing the efforts of the government, but bringing private sector financing, management, and reputation to bear upon the population problem in Turkey."

Mr. Koc earlier pioneered the establishment of a family planning clinic in one of his factories in Bozkurt Mensucat. Mindful of the contribution this made, he campaigned with other business and labor leaders, thirty of whom joined him as founders, to put the Family Health and Planning Foundation on its feet both financially and institutionally. These leaders all share the conviction that rapid population growth and uncontrolled migration have a negative impact on social and economic development in Turkey.

The foundation, a significant innovation on the Turkish scene, complements the government program by introducing, through the business and labor communities, efficiently run, potentially self-financing family planning services.

Meanwhile, the country's most powerful body of organized labor, the two-million strong Confederation of Turkish Trade Unions (TURK-IS), led by its president, Sevket Yilmaz, is working on a precedent-setting parallel track. Population and family planning issues have become a top priority for labor leaders, particularly as the decline in economic activity in Turkey and dwindling labor markets in Europe, which have historically absorbed thousands of Turkish workers, have conspired to push unemployment above the 3.5 million mark. This, coupled with new laws expanding the government provision of family planning services, has prompted the confederation's leadership to undertake dramatic support for family planning.

No stranger to advocacy, TURK-IS has added family planning to its roster of social service demands, such as occupational and safety health standards, family allowances, maternity leave, provision of day care for workers' children, and pensioners' welfare systems. To underscore its commitment to family planning, TURK-IS has developed its own population policy statement — the first such proclamation from any nongovernmental organization in Turkey.

Turkey particularly demonstrates the main strengths of private sector involvement: dedicated leadership and workers, commmunity involvement, efficient use of resources, responsiveness, and flexibility. With industry and organized labor working hand-in-hand, Turkey's chances for success are brighter.

Turkiz Gokgol-Kline
The Pathfinder Fund, Istanbul

Sunday Uner
Haceteppe University, Ankara

Mete Toruner
Confederation of Turkish Labor Unions

Brazil: Local industries in several Latin American countries distribute contraceptives.

M. WANNER

long term, influence legislation to require factory owners to provide contraceptive services to their employees. Once an agreement with management is reached, family planning services are offered through factory health facilities while Planned Parenthood staff give lectures and distribute information to workers. Volunteers are recruited from among workers and their families to receive the training needed to distribute contraceptive supplies. Since 1972, more than 200 factories and at least 150,000 people have come under the program.

Indonesia Industry service programs also are spreading in Indonesia. The P.T. Imbritex textile factory of East Java began offering family planning through its company health service in 1974. Company management and union leaders agreed on various incentives and disincentives to persuade the factory's entire 1,800 workforce to consult its family planning clinic. By 1978, Imbritex reported that the workers' smaller family size resulted in a "reduction in the total overall problems arising in the workers' daily lives." The drain on the company's medical care budget has also been reduced. Another company, Pertamina Oil Enterprises, sends outreach staff from its family planning clinics into workers' homes and has introduced family planning into courses to upgrade the skills of workers who have been selected for promotion.

Jamaica, Guatemala and Colombia In another part of the world, the Sugar Industry Welfare Board in Jamaica has long provided services on an industry-wide basis, and some 28 other industries, including large bauxite companies, are now following its lead. The private family planning association of Guatemala provides services to workers in coffee and cotton plantations while its counterpart in Colombia runs more than 570 contraceptive distribution posts for coffee growers in eight provinces.

Korea In some countries, government and private efforts go hand-in-hand. The Korean government has a policy of attaching public clinics to firms with more than 500 employees and providing tax exemptions in exchange for company subsidization of the clinic's family planning services.

Brazil: Women workers benefit when family planning services are available at their workplace.

PATHFINDER

International Support Groups

The International Labor Organization (ILO), through its Workers' Education Program on Population, which has received strong support from the International Confederation of Free Trade Unions, has played an important role in stimulating industrial sector interest in family planning throughout the world. The ILO encourages both industry and rural cooperatives to introduce family planning education. Pioneering courses for rural workers have also been set up, as well as a program to train discussion leaders and integrate population education into existing "young workers'" education programs. Experimental courses aimed at training family planning motivators have been organized in Sri Lanka, Egypt, and Pakistan.

Local private Family Planning Associations, affiliates of the International Planned Parenthood Federation (IPPF), campaign among trade unions, employers, and other groups within industry in many nations to provide family planning services to those in the workplace—sometimes as part of a package of welfare entitlements—from factory workers in Bangkok, Thailand, to fisherfolk in the Rio Grande do Norte, Mexico.

A Wider Concern

"There is little doubt that the technical resources and managerial talents of organized industry have a function in society and obligation to the community much wider than...business." The sentiments of Shri J.R.D. Tata, head of Tata Industries, are being repeated in many Third World countries where economic growth encompasses broad development issues.

Limiting family size enriches workers' lives and improves the quality of the workforce. Family planning services are being considered by many businesses interested in keeping well-trained employees in their jobs, helping ease domestic problems which contribute to absenteeism, and educating their workers to assume more responsibility for their families and communities. What Sorab Godrej of Godrej Industries said of his own program is true for all: "This project is something we would like everyone to emulate. Now we want to try and help people who are not working for us. It is dangerous to have an island of prosperity in a sea of misery. The whole idea is to set a good example to the country."

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Nigeria: Traditional medical practitioners are being enlisted to offer contraceptive services and to encourage couples to adopt family planning.

T. GREEN

Enlisting Private Practitioners

I-cheng Chi, M.D., and May Huang

May Huang is Deputy Director of the Bureau of Public Health, Department of Health, Republic of China (Taiwan). I-cheng Chi is Associate Director of the Clinical Trial Division, Family Health International, a nonprofit international research organization on family planning and maternal and child health.

Private doctors, midwives, traditional medical practitioners, and pharmacists are important sources of services and information about contraceptive methods. Whether offering traditional services to the public, sharing partnership in a clinic, or working for an organization, private medical practitioners who are adequately trained in providing contraceptives can also play an effective role in motivating couples to adopt family planning.

In many countries, including many in the developing world, those in the private medical community were the first to respond to individual demand by providing family planning services. They have almost always been the principal source of information and services for the upper and middle classes, who, in turn, have influenced the less privileged, either by direct contact or by example.

Private practitioners often anticipate government policy because they see the suffering associated with unregulated fertility more vividly than do administrators or politicians. In Brazil, for example, first pharmacists and private doctors, and then private voluntary organizations were instrumental in introducing family planning. A group of gynecologists and obstetricians, appalled at Brazil's high rate of illegal abortions, started the pioneering, private family planning association, the *Sociedade Civil de Bem-Estar Familiar*. Family planning

is now widely practiced in Brazil, particularly among the higher income groups, despite the absence of a national population program and the many contrary pressures due to religion and pronatalist tradition.

In most developing countries, particularly in Africa, there is a low ratio of doctors to patients. Nevertheless, doctors, midwives, and traditional healers, even those who practice in isolated areas and lack sophisticated medical equipment or the opportunity to refer their patients to hospitals, are well placed to provide family planning services. Many people have greater trust in private practitioners than in government institutions and will use private services, even at a higher cost. Whether this trust is justified is irrelevant. In family planning, a user's perception is crucial and private practitioners are often perceived to offer better, more confidential services while government services, requiring long waits, are considered "second-class."

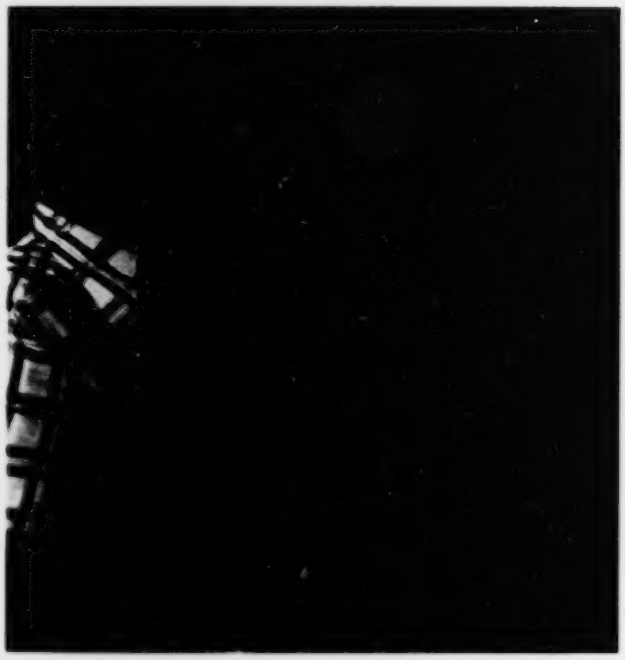
Cost Effective Services

From the standpoint of national investment, it can be more cost effective to use existing private outlets than to create a new infrastructure of government family planning clinics. Current medical technology allows private doctors, both generalists and specialists, to provide family planning services in their offices. Almost all have facilities adequate for IUD insertion and the prescription of oral contraceptives. A great many are also equipped to perform male sterilization, and a considerable number have the facilities appropriate for female sterilization and the treatment of incomplete abortion. In countries where doctors are scarce, other practitioners, such as midwives or nurses, can safely provide oral contraceptives or IUDs if given the proper training and equipment.

Private practitioners, unlike health providers in government service, are not burdened with heavy administrative demands, and they tend to apportion their time according to financial opportunities. Thus, when a government chooses to "buy into" the private sector, not only can it often do so at a cost below that of government services, but it can also ensure that the personal, social, and economic need for family planning is met without undue competition with other government-backed health services.

As early as the late-1950s and early-1960s in some Indian states and Egypt, the government paid doctors and paramedics for providing family planning services.

Costa Rica: Private physicians in the developing world have often been family planning pioneers in their own communities.



India: Adding family planning to the skills of private health practitioners is a cost effective way of providing services.

IPPF/DAVID BEATTY

Training the Medical Practitioner as a Family Planning Counselor

The ability to counsel couples about their contraceptive options and help them make decisions based on their own needs and feelings is a skill surprisingly few private medical practitioners in the developing world possess. The considerable influence of doctors, midwives, traditional healers, and pharmacists may not be put to use because they lack the knowledge to provide family planning services and counseling. Many do not recognize their own misconceptions and therefore may transfer inaccurate information about contraceptives to their clients. On the other hand, given adequate training, private practitioners can complement national family planning programs by making contraceptives more popular and by prolonging their use.

The first step in training medical practitioners to provide family planning services is to find out what information they lack. A technique now being adapted from commercial market research is to begin with a "focus group discussion" to determine what issues should be addressed during training. This in-depth discussion usually involves 8 to 10 representatives of one profession—such as nursing or pharmacy—to elicit information about their attitudes, knowledge, beliefs, and misconceptions. Under the guidance of an experienced moderator, the participants themselves are encouraged to direct the discussion.

Once private practitioners are medically trained to administer contraceptives, they need to learn how to counsel couples interested in family planning. Practitioners who are unable to translate technical information into images and language that the public can understand will not be able to communicate vital information about the use, side effects, contraindications, advantages, and disadvantages of the contraceptive methods available.

Training materials prepared for private medical practitioners could include not only information suited to the local culture about different types of contraceptives (especially new products and procedures), but also tips on counseling and how to give practical answers to common questions. Most private medical practitioners—from MDs to local healers—need training in the use of educational aids, such as booklets, posters, fliers, or flip charts. These educational aids can help provide consistent information, facilitate understanding by illustrating a sensitive topic, and eliminate the need to use potentially embarrassing language. Training programs could also include information about why specific educational aids were developed and provide practice in using them.

If training programs provide accurate information about contraceptive methods, and suggestions about how to communicate that information to patients, private practitioners can become effective spokespersons for family planning.

Margot Zimmerman
Director of Communication,
Program for the Introduction and
Adaptation of Contraceptive Technology

Similar subsidies have since been adopted in more than 15 other countries, including Bolivia, the Dominican Republic, Ghana, and Zimbabwe.

In Taiwan and Korea, private physicians have been constructively involved in national family planning programs by providing a major portion of the contraceptive services. This is in contrast to countries such as the Philippines, Indonesia, Bangladesh, Sri Lanka, and Kenya where the use of private practitioners in government programs is less prevalent. In many countries, doctors employed by government hospitals and institutions also see private patients.

In Taiwan, where fertility has dropped from 5.6 births per woman in 1961 to 2.1 in 1986, there are fewer than 400 government health centers providing family planning, but more than 1,500 private doctors who have contracted with the government to insert IUDs and perform sterilizations. By contrast, in the Philippines, the government has invested in almost 4,000 family planning clinics, but has not involved private practitioners. Contraceptive use is considerably higher, for less capital investment and lower cost, in Taiwan

than in the Philippines.

Couples in Taiwan are referred by government field workers to private physicians as well as hospitals and health stations for family planning services. Seventy-five percent of IUD insertions and 80 percent of sterilization procedures provided by the national program are performed by private doctors, who are paid on a fee-for-service basis according to standards set by the program.

In Taiwan, a couple interested in obtaining a sterilization is given a coupon with a list of clinics and hospitals providing services. The coupon, either stamped "self-paid" or indicating that the fee will be subsidized by the state, is then used to make an appointment and, once the sterilization is performed, sent to the local government health bureau for recording. Thus, the coupons serve as a referral between the health agencies and the contracted hospitals or clinics; as a means of indicating that the procedure has been performed and payment is due; and as a device for obtaining feedback on the program. The private fee for sterilization, based on the minimum expenditure required to perform the operation in a government hospital, is the same whether it is paid by the couple or subsidized by the government for low-income groups.

In Korea, nearly all sterilizations are performed by private doctors, whether paid by the government family planning program or by the individual. County health centers assume the primary responsibility for supplying other contraceptives.

Enlarging the Potential

The role of private practitioners in the provision of family planning services can be developed much further in most countries. Restrictive laws and regulations can be eliminated or modified. In Brazil, where private doctors in some of the more developed areas provide almost the same amount of contraceptive services as private doctors in the United States, several laws that have long impeded the expansion of family planning services have gradually been revised or removed. Article 20 of the Penal Code was reworded in 1979 to make it no longer a crime to advertise contraceptives. Advertising abortion services, which remain illegal except to save the woman's life, is still prohibited. A restrictive 1970 directive of the Ministry of Health requiring prescriptions and allowing only pharmacists to sell the contraceptive pill was dropped in 1976. Female sterilization had been illegal under the Code of Medical Ethics, except in certain cases with the approval of two physicians. In April 1985, the code was revised making approval for sterilization easier to obtain.

Training programs for nurses, midwives, and other health practitioners, as well as for doctors, can be expanded. Highly qualified doctors are needed to tackle the serious problems encountered in countries where there is considerable endemic disease but a dearth of medical expertise. Training nurses and midwives to deliver contraceptives, even surgical family planning services, would release highly trained obstetricians and gynecologists for more pressing medical emergencies.

The newer family planning technologies can be disseminated in such a way that private practitioners can increase their volume of work and lower their fees. A practical way to train physicians, supply equipment, and ensure a continuous supply of commodities needs to be developed, and, where needed, governments should find simple and reliable ways of reimbursing practitioners for providing family planning services. Underpinning these efforts, the philosophy could be firmly established that private physicians complement but do not compete with government services.

The involvement of private practitioners in family planning works because it bestows benefits on all parties involved. The response of private doctors to government payment on the fee-for-service basis has been demonstrably effective in meeting the people's needs and in using scarce resources responsibly. Through this system, governments are provided with a cost effective, relatively easy-to-administer system with a low political profile. Clients receive quality service in a familiar setting for which they have high regard and trust. Doctors who organize their services and take advantage of the fact that even the surgical procedures of family planning are relatively simple and predictable operations when performed on healthy patients, profit even by charging modest fees.

There is great potential for increasing private practitioners' involvement in providing family planning services — from participating in nongovernment health maintenance organizations in Latin America to providing family planning along with traditional medicine in rural Africa. A fuller use of the skills and resources of private health care providers can provide at least part of the answer in countries where the demand for contraceptives is pressing.

Thailand: Community incentive projects encourage small families and enable villagers to borrow money to develop small businesses like this home silk industry.

J. HINDS

Thailand: A village loan fund committee meets regularly to review loan applications.

F. PENGHAM

Motivating Communities Through Economic Incentives

Mechai Viravaidya and Donald Weeden

Mechai Viravaidya, sometimes called Thailand's "Mr. Contraception," is founder and director of the Thai Population and Community Development Association, a private grassroots family planning services organization. He is also the official Thai government spokesperson. Donald Weeden is staff associate with Columbia University's Center for Population and Family Health. He was instrumental in documenting the success of the Community-Based Incentives/ Thailand project and is currently developing similar projects in other countries.

In societies where tradition and the economy favor large families, one effective way to expand the use of family planning is to tie it to economic gains for the entire community. Grassroots groups that actively involve leaders and individuals at the neighborhood level, whose services range from income generation and water projects to agricultural extension, can relate these high priority community demands to the need to reduce fertility. As contraceptive use rises, whole communities are rewarded with money or materials that can be used for self-help activities.

Private Initiative in Thailand

The pilot Community-Based Incentives/Thailand program in northeast Thailand illustrates the high level of contraceptive prevalence that can be achieved when entire communities profit from economic incentives. This "community incentives" program began in 1983 with funding from the Special Projects Fund of the Population Crisis Committee, under the auspices of Thailand's largest nongovernmental organization, the Population and Community Development Association (PDA). PDA, with its long and impressive record as a grassroots family planning service network, had almost a decade of experience in creating demand for family planning by offering income generating incentives to individuals, such as subsidized seeds and fertilizer, or the loan of buffaloes for plowing. The widespread public

appeal of individual incentives led to the development of the community-based program, which turned the focus on entire villages rather than on separate households.

Through the community incentives program, PDA used the grant from abroad to establish loan funds of about $2,000 in each of six villages. The loan funds grew in size as the overall contraceptive prevalence rate in the villages increased. Loans between $80 and $200 were made available to villagers for income-generating activities, mostly to buy fertilizer, rent tractors, or hire workers for planting and harvesting the local crops of cassava, rice, and kenaf, a plant similar to jute. Villagers also used loans for pigs, fish ponds, and other small business ventures. Elected villagers administered the funds and reviewed loan applications with assistance from PDA.

In most villages, the demand for loans at first outstripped the supply of money available. To provide a secure financial base for the fund at the start of the project, greater emphasis was placed on the applicants' character and credit-worthiness than on their contraceptive use. However, as the fund became established and the promotion of family planning grew, contraceptive use became an increasingly important factor in the loan review process.

By the end of two years, loans totaling $72,000 had been granted in the six villages, and 75 percent of all village households had received at least one loan. Repayment was nearly 100 percent on schedule with no defaults. The six loan funds are still operating in 1986, but without outside assistance. PDA advisors are helping community leaders take over complete management of the funds.

Contraceptive practice jumped from 46 percent to 75 percent of all married women aged 15 to 44 in the six villages between 1983 and 1985. In a comparative study of three villages in which no loan fund operated, contraceptive prevalence increased from 51 percent to only 57 percent. As contraceptive prevalence increased, the pregnancy rate in the six program villages fell from 11 percent of reproductive age women to 5 percent.

Studies have shown that this remarkable increase in family planning was achieved without excessive peer pressure and without the feeling that people were being forced to use contraceptives. The motivation of a couple to adopt family planning came not only from the opportunity to get a loan, but also from the flow of reliable information about contraception which the village loan officers provided. The loan fund committee officials, villagers elected by their peers, encouraged family planning for health reasons and became trusted sources of family planning advice.

Incentives Boost Self-Help

In the Thai experience, the private PDA appears to have several advantages over the central government in implementing a community incentives approach. Because PDA works closely with community members, it is able to determine community needs, involve the community in decision-making, and create the foundation for community self-management of the program. It is also able to provide close supervision to make sure that performance is rewarded, and not the traditional power structure. Finally, PDA may well be perceived as a more credible source of rewards than a government that is removed from the people. Few people fear that the grassroots organization will disappear, but national policymakers come and go.

The concept of community incentives is inherently flexible and can be adapted to different cultural or socioeconomic settings. For instance, where there is political sensitivity to tying rewards to contraceptive use, the goal could be broadened to represent overall progress in maternal and child health. Where a long-established organization has been operating throughout a sizable region, incentives could be given to communities achieving the highest contraceptive rate after a period of competition, an approach which has already been used by the governments of Indonesia, India, and Egypt at the regional and state level.

Community incentives may be particularly appropriate where family planning programs are in place, but new ideas are needed to add impetus to the effort. Community incentives projects modeled on the one in northeast Thailand are already under way in two other regions of Thailand. Interest in community incentives has been expressed by private community development organizations in India, Indonesia, Nepal, and Mexico.

Community incentives programs work because family planning and economic development reinforce each other to increase per capita income. Their long-term success will be measured not simply by the extent to which incentives affect contraceptive practice, but by the lasting impact on public attitudes towards increasing self-sufficiency and community welfare.

Bangladesh: River boats spread the message about contraceptives.

PSI

Bangladesh: Contraceptive social marketing makes family planning products affordable in outlying areas.

PSI

Social Marketing of Contraceptives

William P. Schellstede and Bonnie B. Derr

William P. Schellstede is Executive Director and Bonnie B. Derr is Associate Director of Population Services International, a private organization established in 1970 to design and implement subsidized retail sales programs for contraceptives.

A child is pride,
a child is gold;
But plenty children
plenty poverty:
Plan your family!

"Child is Pride," a song based on a Yoruba "talking-drum" proverb and written by a popular local musician, is enlivening the market places of Nigeria while promoting family planning and the use of contraceptives. Using music to attract customers is one part of a pilot social marketing project that has market women selling condoms along with their other wares.

For over a decade contraceptive social marketing programs have provided condoms, pills, and other family planning supplies through retail outlets at a subsidized price for low income consumers. Using commercial advertising to promote these products, contraceptive social marketing is reaching the previously unserved—those too poor to buy commercial products and those not reached by government programs.

Private international development groups have been the prime movers in advancing contraceptive social marketing techniques. Experience with this innovative approach shows that commercial marketing principles not only increase awareness, acceptability, and use of modern contraceptives, but also overcome the massive logistical problem presented by service delivery needs. By employing established commercial

retailers and distributors and drawing on professional research and advertising expertise, contraceptive social marketing programs have involved thousands of people who otherwise would not be in family planning work.

In 1969, with support from the Ford Foundation, a private funding agency, India became the site of the first program designed to tap the tremendous resources of the commercial sector in the delivery of voluntary family planning services. Many countries have since introduced contraceptive social marketing. At the present time social marketing programs are in operation in Bangladesh, Colombia, El Salvador, Guatemala, Egypt, Honduras, India, Mexico, Nigeria, Nepal, Thailand, Sri Lanka, and the Caribbean countries of Jamaica, Barbados, St. Kitts, and St. Lucia. New program initiatives are being developed in Costa Rica, the Dominican Republic, Ghana, Indonesia, Pakistan, and Peru.

The basic difference between social and commercial marketing is the end objective. While commercial marketers are in business to earn profits, contraceptive social marketing exists to prevent unplanned pregnancies. Frequent pregnancies, particularly among the very poor, represent a threat to the well-being of mothers and children, and in the aggregate are a serious impediment to improved socioeconomic development. The need for appropriate intervention is as clear as that for relief in a disaster.

Contraceptive social marketing is only one method of intervention, but its ability to reach large numbers of users and to treat contraceptives as common consumer products, like soap, matches, or tea, has helped diminish social and religious constraints surrounding this intimate subject. Contraceptive social marketing has also stimulated thinking about other ways to engage private enterprise in the overall family planning effort. Furthermore, its techniques have been adapted to deliver information and products in other health-related areas such as nutrition and treatment of life-threatening diarrheal diseases.

How Social Marketing Works

Each contraceptive social marketing program is a variation on a theme tailored to meet specific cultural, social, and management requirements. It includes an organizational structure that can quickly respond to market changes and fulfill contractual obligations as well as function in harmony with local government regulations. A target market is defined and marketing

Bangladesh: A sales promoter makes a pitch for family planning.

PSI

Jamaica: Advertising images and slogans are used throughout the world to make contraceptives more appealing.

research guides program development. A marketing plan outlines strategies for products, prices, advertising, and distribution.

The basic components of contraceptive social marketing programs are identical to those of their commercial cousins. With the exceptions of Colombia and Thailand, noted below, contraceptive social marketing programs work primarily to reach a heretofore unserved market, especially those who cannot afford regular commercial products, and those who are not adequately reached by government programs.

Product and Distribution While there are exceptions, contraceptives generally are provided to a program by a donor organization and include condoms, oral contraceptives, and spermicides. The Egypt and Mexico programs also sell IUDs and a few programs sell injectable contraceptives in limited market areas.

Brand names and package design are developed for each product according to cultural appeal as determined through consumer research. In Bangladesh, condom brand names include "Raja" and "Majestic," while in Egypt they are called "Golden Tops," in Jamaica "Panther," and in Sri Lanka, "Preethi." On occasion a generic or organizational name, such as "PROFAM Condoms" in Mexico, is used. It is not uncommon for product lines to expand and vary their prices to appeal to different consumer groups.

The backbone of any contraceptive social marketing activity is distribution. Getting products on the shelves of stores or out into village markets where people normally shop is the primary innovation of the social marketing method of delivering family planning services. After all, if a product is not available, nobody can buy it. Because of the medical aspects, distributing oral contraceptives, IUDs, and injectables is more complicated than condoms and spermicides, but the notion of easy availability remains important even for these products.

Existing commercial networks represent an effective means to reach a large proportion of the population, but these systems, guided by economics, often do not extend to areas where the cash economy is weakened by poverty and isolation. Contraceptive social marketing programs, especially in poor countries with large rural populations, sometimes have to supplement normal commercial channels with their own sales staff. The training of physicians, pharmacists, and rural

medical practitioners in the proper use of products is another important component in the distribution of social marketing products.

Price The price structure for contraceptive social marketing products has two important functions. First, income from sales compensates the many retailers who are crucial to the objective of widespread distribution. Second, price establishes an image of worth for the contraceptives in the minds of consumers.

Since contraceptives for social marketing are normally provided free or at a nominal price to the organization running the program, they can move from distributers to wholesalers to retailers at prices well below market value, while providing adequate profits along the way. The price of contraceptive social marketing products in most cases is set lower than regular commercial contraceptives, to be affordable to people with little disposable income. While this price level is usually too low to provide a profit to the program as a whole, the money from sales helps offset operating costs and improves overall cost efficiency.

Promotion Advertising is as critical to contraceptive social marketing sales as to commercial product sales. Point-of-purchase materials, mass media (radio, press, television), and non-conventional promotion, such as advertising contraceptives on the sails of boats in Bangladesh, are all used to increase awareness of brands and methods.

Advertising messages are developed to convey product quality and the benefits to be derived from family planning. The Jamaican theme "If you care about life" has been transferred to eastern Caribbean countries. "Until you want another child, rely on Preethi" was developed in Sri Lanka and will soon be adopted in Pakistan.

Many contraceptive social marketing programs have developed innovative and popular methods of promotion to overcome such obstacles as illiteracy and the limited reach of mass media. These efforts have included the use of comic books in Mexico, consumer rallies in rural villages in Egypt, film showings and folk drama to inform and entertain isolated villagers in Bangladesh, and direct mail campaigns in Sri Lanka.

Promotional methods can raise delicate problems of social and political sensitivity. But, where mass media advertising has been allowed, it has generally

Nigeria: When market women are persuaded to sell contraceptives in addition to their usual products, family planning supplies become more readily available.

S. RICH

Sri Lanka: This advertisement promotes contraceptives distributed through a subsidized social marketing program.

PSI

been effective—even in conservative cultures. Frequently, contraceptive social marketing has been the catalyst to effect revisions of long-standing laws or informal taboos limiting the use of media for family planning products. For example, in 1983 the Egyptian program initiated that country's first brand-specific television campaign for contraceptives.

Programs Around the World

The urban-directed Colombian and Thai contraceptive social marketing programs started in the early 1970s with support from the league of private family planning associations, the International Planned Parenthood Federation (IPPF). They are a part of larger activities conducted by PROFAMILIA (the Colombian IPPF-affiliate) and Population and Community Development Associates (a private nonprofit organization in Thailand). These programs are exceptions to the rule in that they seek and do make profits. Each uses its own staff to sell contraceptives to urban retailers, who in turn sell them at commercial prices to largely middle and upper income groups. Neither uses mass media in its promotional activities, but the Thai program, founded by the family planning entrepreneur, Mechai Viravaidya, is noted for its fearless "special events" publicity of family planning, such as frisbee throwing contests using frisbees that sport condom brand names.

Both the Colombian and Thai programs use contraceptive social marketing profits to help offset the operating costs of their rural community-based programs, and both are considered successful. In 1984 contraceptive social marketing condom sales accounted for 90 percent of the 5.8 million total PROFAMILIA condom distribution in Colombia. In the same year, Thailand's contraceptive social marketing sales accounted for 87 percent of the more than 4.3 million condoms distributed through the combined contraceptive social marketing and community-based activities

In contrast are Sri Lanka and Jamaica. When Sri Lanka launched condom sales in 1973 with financial support from IPPF and technical assistance from Population Services International, the project employed a local distribution firm to achieve the broadest possible coverage of retail outlets. Jamaica followed suit in 1975, when condom and oral contraceptive marketing was launched with financial support from the U.S. government and technical assistance from the Westinghouse Health Systems consulting group. An ultimate goal of each program was to reach the rural and urban poor who either do not use contraceptives or are not served by other programs. In pursuit of this goal, profit was not a primary sales objective. Retail prices were highly subsidized to be affordable to the lowest income groups, and mass media advertising as well as other promotional activities played a key role in program achievements.

While the Sri Lankan program has remained in private hands, managed by the Sri Lanka Family Planning Association since 1976, Jamaica's program has been turned over to the country's Ministry of Health, which through the National Family Planning Board assumed program management in 1977. Despite funding cuts in recent years, each continues to sell significant numbers of products. Nearly 1.3 million condoms were sold in Jamaica in 1984, and 4.8 million in Sri Lanka.

Is Social Marketing Effective?

According to experts, more than a decade of experience has shown that if contraceptive social marketing programs are well-managed, well-publicized, and well-adapted to local conditions, they can reach a significant proportion of all couples of reproductive age. Their success is influenced by a variety of factors, including geography, laws, and economic conditions, as well as operating considerations such as management control, relationships with governments and government family planning programs, and funding. Even so, each contraceptive social marketing program operating today can point to a measure of success.

Program achievements are viewed from several perspectives. The number of years of contraceptive protection provided to each couple is the primary measure, but cost efficiency and the general contribution to a country's family planning effort are also important.

A convention often used to estimate the value of product sales is that one year of contraceptive protection for one couple is equivalent to 100 condoms, 100 vaginal spermicide applications, 13 cycles of oral contraceptives, or 4 to 6 injections. One IUD insertion represents 2.5 years of protection. The most impressive contraceptive social marketing sales performances have been in Bangladesh, Colombia, Egypt, and Jamaica. In Bangladesh, sales by the Social Marketing Project in 1984 represented a year's protection for 1.3 million couples. In Colombia, PROFAMILIA sales of condoms and oral contraceptives represented one year of protection for 560,000 couples during 1984, which is 15 per-

cent of married women of reproductive age or, according to reports, 31 percent of all users. In Egypt during 1984 the Family of the Future Project sold an equivalent of 678,253 years of protection, which is reportedly more than 40 percent of all contraceptive users. Jamaica reported 1984 sales at a level of 42,806 years of protection, accounting for roughly 13 percent of married women of reproductive age, or more than 25 percent of all users.

Most contraceptive social marketing programs can point to impressive cost-efficiency records, especially when compared to other service delivery methods. Costs per year of protection per couple generally start high but tend to decline as a project matures. In 1984 in Bangladesh (which started contraceptive social marketing in 1975) the net cost, excluding commodities, was $1.75; in Egypt (started in 1979), $5.26.

The main reason contraceptive social marketing is more cost-efficient than other modes of contraceptive distribution is that the cost of delivering the products is assumed by the commercial system. By contrast, in a typical government delivery system, contraceptives are handled from warehouse to client by salaried workers. Even the Bangladesh project, which is perhaps the most heavily subsidized of the on-going projects with some of the lowest retail product prices, was reported as having the lowest cost per year of protection for methods other than sterilization among the major contraceptive distribution systems in the country. In 1984, recovery of local costs in Bangladesh, Egypt, El Salvador, Honduras, and Nepal were 33, 26, 54, 46, and 18 percent respectively.

The Self-Sufficiency Issue

Because self-sufficiency is an attractive prospect, especially during times of restricted funding and the likelihood of further cuts, some donors are asking whether social marketing programs should pay for themselves. The response raises a fundamental question about the motivation behind contraceptive social marketing. Is it to make profits or to lower fertility? Are such goals compatible? Past experience has shown that the modifications needed to make contraceptive social marketing programs self-sufficient often jeopardize their original purpose: to serve the lower income groups who desire and need family planning methods but cannot otherwise get them.

Programs in Jamaica, Mexico, and Sri Lanka now claim self-sufficiency. In 1984 El Salvador achieved a cost recovery of more than 50 percent. However, viewed from the perspective of demographic effectiveness, self-sufficiency has not been easily won. In both the Mexican and Salvadoran projects, where donor funds were severely reduced, attempts to make up the difference by raising the price of contraceptive products resulted in drastic reductions in sales. In Jamaica, where the social marketing project continues to produce an impressive sales record, the pursuit of self-sufficiency has hindered the consideration of additional investments to improve and expand service delivery. Not only has this resulted in a lack of professional marketing management, it has also delayed clearly needed action, such as the launching of a low-dose pill.

As contraceptive prevalence increases, the need for additional promotion and more sophisticated management grows. But attempts to attain self-sufficiency sometimes detract from this need, and, in Mexico and El Salvador, may have fatally compromised the original purpose of supplying contraceptives to the poor.

While the record of social marketing around the world is mixed, there have been impressive performances. Some issues remain, such as the development of better methods of evaluating projects, yet, contraceptive social marketing has proved to be a cost-effective way to deliver massive amounts of contraceptives. It is hoped that the ability of contraceptive social marketing to generate funds will not obscure its more basic and compelling purpose of delivering family planning services to those most in need.

Thailand: In a Chiang Mai clinic, a woman receives her quarterly injection of Depo Provera.® Not yet approved for contraception in the United States, Depo Provera® has been approved by the World Health Organization and has been used in 80 countries.

J. HINDS

Introducing New Contraceptives

Sheldon J. Segal and Elsimar Coutinho, M.D.

Sheldon Segal is Director for Population Sciences of the Rockefeller Foundation, one of the world's largest philanthropic organizations and a principal supporter of population and family planning programs. Elsimar Coutinho is Professor and Chair of the Department of Obstetrics and Gynecology at the Federal University of Bahia, Brazil.

Many contraceptives, including the pill and the intrauterine device, were developed from cooperative work between private and public researchers in the United States and abroad. Private pharmaceutical companies studied new compounds derived from large-scale chemical synthesis programs. They relied on researchers in the scientific establishment supported both by public funds and by private foundations. Medical schools and hospitals would test the new drugs' biological activity and their possible effect as contraceptives. For example, the first two synthetic hormones that appeared in the contraceptive pill were synthesized by industry chemists, but were tested for biological activity by research scientists at the publicly-supported Worcester Foundation for Experimental Biology and the National Institutes of Health. The chemical that became the basis for the injectable contraceptive Depo Provera® was synthesized in the United States by a pharmaceutical company chemist, but the publicly supported university medical center at Bahia, Brazil, discovered its contraceptive capability.

This form of private-public sector cooperation predominated until the early 1970s when several contraceptive development programs, funded by private foundations, government agencies, and intergovernmental organizations, were formed to accelerate the pace of creating contraceptives suitable for the needs of the developing world. The new research teams began to originate product ideas while continuing to work effec-

tively with industry. The entire effort benefited from using the strengths of each sector of the scientific community.

Out of these collaborations came the main innovations in contraceptive methodology since the original pills and IUDs: the family of copper-bearing IUDs, which have been used by over 30 million women worldwide; the NORPLANT® contraceptive implants, which are distributed commercially in Europe, are under evaluation for approval in the United States, and are finding their way into the family planning programs of many developing countries; and RU-486, a potential once-a-month pill to assure menstruation.

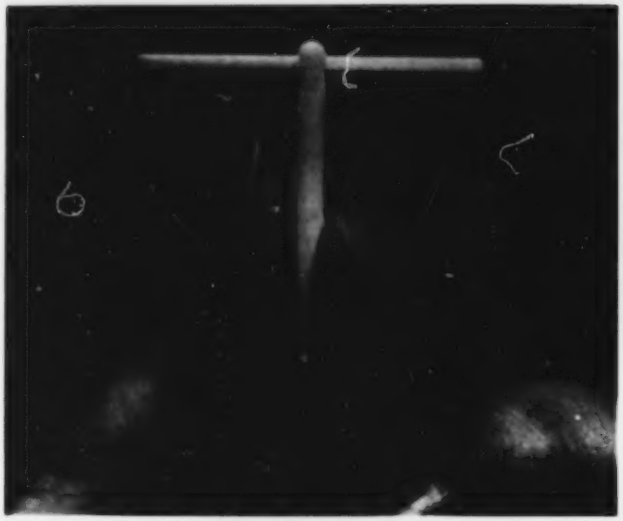
Today, private research efforts to discover new contraceptives are threatened. Drug companies, particularly in the United States, have reduced their interest in contraceptive development because of concern over the rising cost of product liability insurance, the cost of lawsuits in defense of liability claims, and the fear of extremely high awards by juries in product liability cases.

Principles of Agreement

The current form of private-public collaboration, now threatened by the liability crisis, works under a few simple principles of agreement. On the one side, private industry agrees to supply its patented chemical compounds for assessment as contraceptive agents; to be willing to enter into negotiations with public sector organizations to develop the contraceptive drugs if initial tests warrant it; and to release compounds to another company if the patent-holder declines to proceed with contraceptive development. The public-sector program agrees to fund the studies, keep the industry informed, and maintain confidentiality.

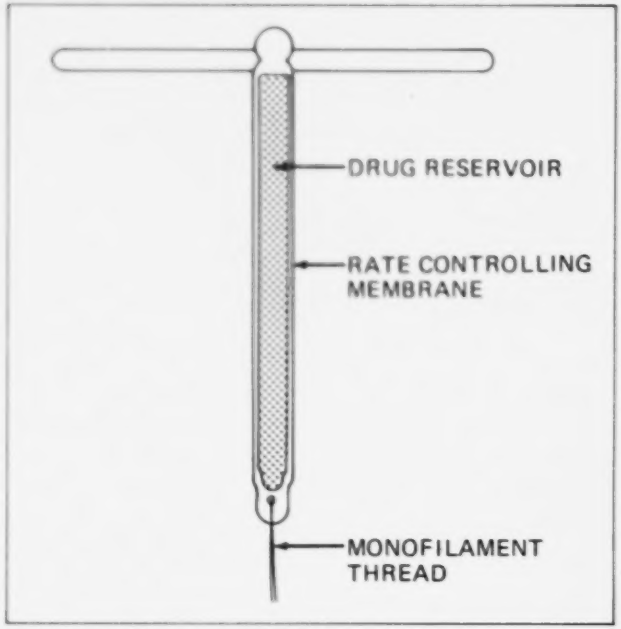
When the technology is discovered by the public sector and is of potential interest to private industry, the collaboration involves other issues. The public agency agrees to supply manufacturing know-how and all biological and clinical information; to license under applicable patents; and to permit cross reference to regulatory agency filings. Private industry agrees to use its best efforts to bring the product to market, to manufacture the product at reduced cost for public sector use, or to provide know-how for others to do so. It also agrees to assume product liability and grant the public sector agency licenses to any patented improvements in its product.

The Copper-T IUD was developed under this type



United States: The Progestasert® Intrauterine Progesterone Contraceptive System manufactured in California is the only IUD still sold in the United States. The U.S. litigation crisis has caused manufacturers to stop making other IUDs for U.S. markets.

ALZA



Projestasert® is part of a new family of IUDs which release small amounts of progestin directly into the uterus.

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of agreement. In a classic example of role reversal, the research initiative, virtually all the method development, and even the regulatory agency filing were carried out and financed by the Population Council, a private foundation which dispenses tax-exempt funds. Private industry took over the responsibility for what it does best—product introduction, distribution and marketing.

On the basis of a patent and license held by the Population Council and an inventor whose work was financially supported by the Council, the original Copper-T-200 was licensed to companies in a number of countries, making it available both to the public sector at preferential prices and to the commercial sector. The resulting savings to public sector family planning programs have far exceeded development costs of the Copper-T. In one purchase of a million devices for the Government of India, the United Nations Fund for Population Activities was able to realize savings of $3 million below the commercial price. On the private market, the device has been a success for manufacturers in the United States, Canada, West Germany, Mexico, Sweden, and Finland who sell it both domestically and through export. All told, more than 25 million Copper-T-200 devices have been distributed worldwide.

The NORPLANT® contraceptive implant was also developed by the Population Council as a part of its comprehensive contraceptive development program. This revolutionary 5-year subdermal implant contains the hormone progestin, a patented chemical of the Wyeth Company of Pennsylvania, USA. Development of the product required cooperative agreements between the Council and Wyeth, and between the Council and the Dow Corning Company, holders of patents covering the medical use of Silastic in which the hormone is encased.

With the participation of an international group of scientists and physicians from Brazil, Chile, Finland, Sweden, and the collaboration of many other colleagues in developing countries of Asia, Africa and Latin America, the implant was taken by the Population Council from the initial stage of basic laboratory work through all the steps required to develop a completed product. The Council had spent about $5 million to develop NORPLANT® by the time it sought the cooperation of a Finnish pharmaceutical firm, Leiras, for its know-how in pharmaceutical preparation and packaging. Ultimately, this cooperation led to a licensing agreement which gives Leiras non-exclusive marketing rights, using the Council's massive data base for regulatory agency filings throughout the world.

Obstacles to Contraceptive Development

Contraceptive research both inside and outside the United States is feeling the chilling effect of the U.S. litigious atmosphere. Companies from abroad, once eager for a share of the lucrative dollar market in the United States, now wish to steer clear, even though these companies would be prepared to meet the requirements of the Food and Drug Administration, the U.S.'s official regulatory agency. Contraceptives, considered to be high risk targets for lawsuits, are receiving little of the research budgets of pharmaceutical companies.

Opposition from anti-abortion forces has also had an effect. The laboratories outside Paris of the Roussel Uclaf pharmaceutical firm, which sponsors RU-486, have come under considerable pressure to abandon the drug, particularly from anti-abortion forces in the United States, because of the compound's potential use as a chemical abortifacient.

The attacks of those under "the right to life" banner have broadened to include contraception, as anti-abortion forces oppose the use of any method of contraception they consider to be "unnatural." They condemn any method which they consider to work as an abortifacient—whether or not there is substantiating evidence. Yet, when the availability of effective contraception declines, the number of unwanted pregnancies and of abortions increases. In the light of this reality, contraceptive research can be truly described as anti-abortion research, and the provision of effective contraception an effective means to prevent abortions.

The Outlook

When the Population Council received new drug approval for the Copper-T-200, it was the first time the U.S. Food and Drug Administration had issued approval to a noncommercial sponsor. This unprecedented event established a new phase in the cooperative efforts between industry and the nonprofit sector to develop contraceptive products. It proved that given adequate funding, nonprofit agencies can carry out full product development, including the initial regulatory agency clearances.

The Pharmaceutical Industry's Role in Selling Contraceptives

In most developed countries, the pharmaceutical industry is responsible for manufacturing and marketing contraceptives. In developing countries this role has generally been limited to manufacturing with the distribution and promotion of contraceptives handled by subsidized family planning or social marketing programs. As a result the commercial market for contraceptives is very small in most developing countries and is often ignored in discussions about ways to improve family planning services.

Of the three kinds of contraceptives produced by pharmaceutical companies — oral contraceptives, intrauterine devices, and injectables — oral contraceptives are the most important commercially. Pharmaceutical firms are willing to invest in the oral contraceptive market, but recognize they face consumer resistance. Although recent surveys in both developed and developing countries indicate that women believe there are health risks in using the contraceptive pill, there are strong medical arguments in favor of expanding the contraceptive commercial market by offering the pill over the counter, without prescription.

Today's birth control pills contain lower doses of hormones, reducing the side effects and health risks linked to the higher dose pills of previous years. In addition to the obvious health benefits of preventing unwanted pregnancies in countries where maternal and child mortality is high, pills are associated with lower rates of some pelvic infections and reduced risk of ovarian and uterine cancers. The most important negative aspect of pill use is the increased risk of blood clots and heart attacks, but this risk is largely confined to older women and may be less prevalent in the developing world where cholesterol rates are lower and women smoke less.

Despite consumer fear, even in countries with very low per capita income, the size of the potential commercial market is sufficiently attractive to warrant an advertising campaign directed at users. But the pharmaceutical industry has been prevented from tackling the problem in many countries by government restrictions on contraceptive advertising. This dilemma also applies to injectable contraceptives and, to a lesser extent, IUDs, which require trained personnel for insertion and follow-up.

Oral contraceptives are usually promoted in the developing world by medical and family planning workers. Allowing the pill to be advertised and sold over the counter without a perscription would provide the primary impetus for expanding the pharmaceutical industry's role in reaching the many people still in need of contraceptives. Consumer promotion might take the form of cinema commercials, radio jingles, displays in pharmacy shops, and lay press advertisements. But even in the handful of countries where advertising nonprescription pills is allowed, it is rarely practiced because the pharmaceutical industry anticipates strong opposition from doctors who fear a loss of income and status if the pill becomes widely available over the counter.

In countries where the pharmaceutical industry is allowed to advertise contraceptives, the promotional activities focus on eliminating women's fears of adverse side effects. A more liberal policy on advertising oral contraceptives could not only increase commercial sales, but also have a favorable impact on the overall use of birth control pills and thus precipitate a spin-off effect that could benefit contraceptive social marketing and family planning programs as well. A commercial advertising campaign aimed at higher income customers would also reach potential users of government services and contraceptive social marketing programs. Advertisement, after all, conveys more than a brand sales message. It helps dispel fears about health risks and shows that the use of oral contraceptives is part of a desirable life-style and not merely relegated to the poorer segments of the population.

The private sector approach is cost-effective because it uses established systems of distribution and

continued...

promotion which are also used for other prescription drugs or over the counter preparations. Abolishing the compulsory medical involvement in pill distribution would in itself considerably reduce the cost of contraceptive protection. The budget for educational and advertising campaigns would be provided by company revenues as the selling price of contraceptives allows sufficient income for the manufacturer to extensively promote the product, both to the medical profession and to the consumer.

In Bangladesh, one of the few developing countries where advertising (including brand names) is allowed and widely practiced, and where commercial marketing works side by side with government services and contraceptive social marketing, the private commercial market is 10 times larger than in Indonesia, where the promotion of oral contraceptives is restricted. This comparision is particularly striking given the fact that the population of Indonesia is 60 percent larger than that of Bangladesh and GNP per capita over four times greater.

Pieter Muntendam, M.D.
Medical Advisor
Organon International

(The views expressed are those of the author and do not necessarily represent those of Organon International)

For companies, this resource in contraceptive development offers a new option that removes the uncertainty of cost and time required to develop contraceptives. Were it not for the crisis in liability insurance and litigation in the United States, the precedents that have been established for cooperation between the public and private sectors could serve as the basis for rapid advances in the contraceptive field. Under normal circumstances, companies interested in marketing contraceptives would find considerable appeal in the most effective IUD in the Copper-T family, the TCu 380A, which is already developed, tested and FDA-approved. Ironically, although the device was developed with funds provided by tax-exempt U.S. foundations, women in the United States may be the only ones in the world who cannot obtain the device in their own country because of the threat of litigation.

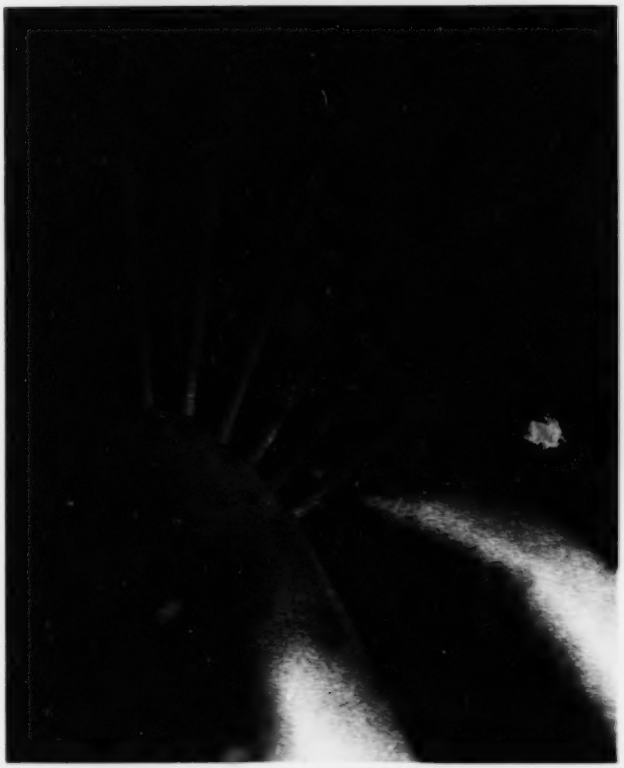
In spite of the present difficulties, the contraceptive research field seems poised for major advances in the coming years. There has been sufficient experience accumulated to demonstrate to both parties the advantages of cooperation between the private and public sector. In particular, with the impressive performance of the Copper-T IUDs and NORPLANT® implants, public sector programs have captured the respect of private sector research managers. It has not escaped their attention that these true innovations, with substantial potential for opening new markets, have been achieved at relatively low cost, compared to industry R&D estimates.

The relative advantages of each sector have come clearly into focus—private industry excels at the beginning of the process, and at the end—the synthesis of new chemicals on the one hand, and product introduction and marketing, on the other. The public sector, which can mobilize the talents of the international academic, scientific community, is effective in discovering new leads and carrying these through the testing phases. The registration procedures with drug regulatory agencies can be expedited by close public-private sector cooperation.

Even now a glimpse of the contraceptive future includes vaccines for women or men, a pill for men, improved contraceptive implants, and new injectable contraceptives for use by women. The mechanisms for their development are in place. Publicly supported programs are now engaged in highly efficient collaborative work on these leads. The collaboration and cooperation

among publicly supported programs is in itself an asset that strengthens the field considerably. The field is weakened, however, by the limitations felt by the private sector due to the problems surrounding liability insurance and litigation.

In the years ahead, with adequate funding, and an appropriate solution to the problems constraining industrial participation in contraceptive research and development, totally new methods of fertility regulation could emerge from the scientific work in progress.



Finland: NORPLANT™ provides protection from pregnancy for five years when implanted beneath the skin of a woman's arm. The method is reversible when the implants are removed.

H. MORGAN

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